6. A. For professional services rendered by a physician, or osteopath, or nurse anesthetist, or nurse practitioner, reimbursement will be the lower of:

1. The provider's customary charge to the general public;

2. The Department's fee schedule.

The Program reserves the right to negotiate and establish a different fee for a physician or a group of physicians under contract to a hospital to provide services when a portion of the cost of the contract is paid as the hospital's cost, provided this fee does not exceed limitations set forth in (1) - (2), above.

B. For professional services rendered by a podiatrist, physical therapist, dentist, or optometrist, reimbursement will be the lower of:

1. The provider's customary charge to the general public;

2. The Department's fee schedule.

7. Payment for each of the other services included in the State Plan shall be as follows:

a. Outpatient Services -- Hospitals.

(1) All hospitals located in Maryland which participate in both the Program and the Medicare Experiment (under the waiver as described on page 2 of this attachment), except those listed in (2) below, will charge and be reimbursed according to rates approved by the Maryland Health Services Cost Review Commission (HSCRC), pursuant to HSCRC regulations. Under this system, all participating hospitals are required to submit data on base and budgeted years, using a uniform accounting and reporting system. Rates are approved for units of service in the various revenue producing departments and are periodically adjusted for such items as inflation, volume changes, and pass-through costs.

(2) The Maryland Department of Health and Mental Hygiene will make no direct reimbursement to any Maryland State-operated chronic, psychiatric, or tuberculosis facility.

(3) An acute general or special hospital whose rates have not been approved by the Health Services Cost Review Commission will be paid the lower of reasonable costs or charges in accordance with the provisions of Title XVIII regulations.

b. Free-standing clinics are to be reimbursed at a rate not to exceed reasonable cost. Rates of reimbursement vary according to type of services provided. Each type of clinic has a negotiated maximum rate which is applicable to all clinics within that type.

c. Home Health Agencies - reimbursed at the lowest of the provider's actual charges, the provider's actual, allowable costs or the Schedule of Limits on Home Health Agency costs per visit as published in FR 20616 - 20629 (1984) and any amendments to it.

d. Disposable Medical Supplies and Durable Medical Equipment

(1) For repairs:

(a) Wholesale cost plus 40 percent to the provider for all materials;

(b) Reasonable charges for labor not to exceed the usual and customary charge for similar services in the provider's area.

(2) For covered services at the lowest of:

(a) The provider's customary charge to the general public;

(b) The Department's fee schedule;

(c) The manufacturer's suggested price.

(3) Home Kidney Dialysis Supplies (Purchase or Rental)

The Department shall pay the cost approved by the Kidney Disease Program for all disposable medical supplies and durable medical equipment for home kidney dialysis purchased or rented for Medical Assistance recipients.

(4) The Department shall pay providers usual and customary charges for prosthetic devices. This fee will include all fitting, dispensing, and follow-up care.

e. Eyeglasses - reimbursed at the provider's acquisition cost up to the maximum rates established by the Program. Acquisition cost is defined as the actual cost of a product to a provider before the deduction of discounts and allowances.

f. Independent laboratory services, x-ray services - reimbursed on a maximum fee schedule using Current Procedure Terminology (CPT) codes.

g. Health Department clinics are reimbursed on a cost-related basis.

h. Drug Abuse Clinics - reimbursed a maximum per patient, per week rate.

i. Family Planning Clinics - reimbursed at a per visit rate.

STATE OF MARYLAND - Transportation

j. Transportation services are reimbursed according to the following:

(1) Ambulance Services (COMAR 10.09.13)- pay only the authorized Medicare coinsurance and deductible amounts.

(2) Transportation Grants (COMAR 10.09.19) - these transportation services are provided as an administrative expense. Grants-in-Aid are awarded to an agency in each local jurisdiction. The original method of allocating the grant monies attempted to account for five factors:

a. Current enrollment;
b. Availability of public transportation;
c. Distance from the Baltimore/Washington area;
d. Actual SFY 1992 expenditures; and
e. Cost of administering the program.

Each year, the individual local agency grant award is adjusted up or down based on documented need.

(3) Transportation Services under the Individuals with Disabilities Education Act (IDEA) (COMAR 10.09.25) - these transportation services are provided as an optional service for only those individuals who qualify for and require it as part of their Individualized Education Program or Individualized Family Service Plan. When the criteria are met, a provider will be reimbursed the fee established in the regulation. This fee was established by determining the actual statewide cost to transport these children to or from their service.

(4) Emergency Service Transporters (COMAR 10.09.31) - pay enrolled providers for transporting Medicaid recipients to appropriate facilities in response to an emergency "911" call. The fee for this service is established in the enabling legislation.

k. Rural Health Clinics - Rural Health Clinics are reimbursed at a per visit rate established by the Medicare carriers.

l. Personal Care Services*

(1) Payments to personal care providers will be on a per diem basis and limited to the maximum number of days for which each recipient is certified eligible for services. Levels of payment for personal care services are based upon the needs of the recipients. Payment will be made according to the fee schedule which is set by regulation and will include payment for days spent in Departmentally approved training.

* The cost of latex gloves is not included in the fees paid to the personal care aides.

|2| Payments to case management providers will be on a monthly basis and include all actual personal care cases under management during the period specified. Payments are according to the fee schedule in effect.

m. Medical Day Care Services - The maximum per diem rate shall be established annually by adjusting the maximum per diem rate for Medical Day Care for the preceding fiscal year by 80% of the annual increase or decrease in the March - Baltimore Metropolitan Consumer Price Index - W. Urban Wage Earners and Clerical Workers.

n. Hearing Aid Services - Hearing aids an accessories are reimbursed at the providers's acquisition cost which is defined as the actual cost of a product to a provider before the deduction of discounts and allowances. For replacement materials, the maximum reimbursement is acquisition cost plus 50%. All professional services are reimbursed according to the fee schedule or the provider's usual and customay charge, whichever is less.

o. Oxygen and Related Respiratory Equipment.

|1| For covered services at the lower of:

|a| The provider's customary charge to the general public;

|b| The Department's fee schedule.

|2| For repairs to purchased respiratory equipment in accordance with the following:

|a| Actual cost to the provider for all materials; and

|b| Reasonable charges for labor, not to exceed the usual and customary charges for similar services in the provider's area; or

(c) Actual charges for repairs done by other than the provider as evidence by an invoice attached to the bill

p. Free-standing dialysis facilities services - reimbursed for dialysis services in accordance with the provisions of Title XVIII regulations.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

WASHINGTON, D.C. 20201

87-3

JUN 6 1977

Neil Solomon, M.D., Ph.D.
Secretary
Maryland Department of Health
and Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Dr. Solomon:

Your request for waivers for Title XIX under Section 222(b) Public Law 92-603 has been reviewed and approved. The pertinent citations for the waivers are: Section 1902(a)(13)(D) of the Social Security Act; 45 CFR 250.30(a)(2)(i)(ii) and (iii), and 45 CFR 250.30(b)(1). The waivers are granted for one year only. It will be necessary to submit a request for continuation to proceed beyond the one year. The waivers will become effective beginning July 1, 1977, and will end on June 30, 1978. The granting of the stated waivers for Title XIX will coincide with the beginning date of the waivers granted for Title XVIII by the Social Security Administration.

The experimental demonstration to be conducted in relation to these waivers is that contained in SSA Contract No. 600-76-0140 between your office and the Social Security Administration. That contract will now pertain in full to the Title XIX inclusion and all restrictions and conditions therein shall be likewise in effect, including the application of a CAP formula guaranteeing a limit to Title XIX program expenditures. The Federal project officer assigned shall develop any contract adjustments necessary to effect the inclusion of the Title XIX portion into that experimental demonstration contract.

RECEIVED

JUN 09 1977

Sincerely yours,

Robert A. Derzon
Administrator

bcc: Regional Commissioner, Region III
Commissioner, Social Security Administration

ST. Md CO Approved 9-28-81

RO Approved 11-2-81 [illegible] 7-1-81

82-3

Mr. Charles B. Buck, Jr., Sc.D.
Secretary
Department of Health and
Mental Hygiene
201 West Preston Street
Baltimore, Maryland 21201

Dear Mr. Buck:

Your recent request for a 3-year waiver of Medicaid reimbursement principles has been approved under the authority of Section 402 of the Social Security Amendments of 1967 as amended by Section 222(b) of Public Law 92-603.

This approval permits the uninterrupted continuation of the hospital prospective rate setting experiment presently being conducted by the Maryland Health Services Cost Review Commission under Health Care Financing Administration (HCFA) Contract No. 600-76-0140. The waivers are subject to the following terms and conditions:

1. Any substantive change in the current rate setting methodology of the MHSCRC as the result of the developmental program shall be subject to the prior approval of HCFA before its application to participating hospitals.

2. Waivers for the inclusion of chronic disease hospitals in the demonstration are approved subject to final review and approval of the rate setting methodology by the HCFA project officer.

3. The present payor differential for Medicaid contained in HCFA Contract No. 600-76-0140 shall remain in effect until such time that the Commission submits justification for a revised differential and it is approved by the HCFA project officer.

RECEIVED
JUL 3 - 1980
MANAGEMENT AND FISCAL SERVICES

RECEIVED

9-28-81

11-2-81

7-1-81